Insured and/or administered by:

Cigna Health and Life Insurance Company

Dow Chemical Company

Benefits at a Glance
Global Plan for all covered Employees.
Policy # 02002A
Plan Start Date January 1, 2025

This plan provides minimum essential coverage.

NOTE: This information is a general description of benefits and is not a contract. Refer to your certificate booklet for complete details of coverage and exclusions. If there is any difference between this summary and the certificate, the information in the certificate will apply. Please note that your plan does not cover expenses for services which are not medically necessary.

Cigna Global Customer Service

Toll Free Telephone Number: **Direct Telephone:** **Toll Free Fax Number:** **Direct Fax Number:**	1.800.441.2668 1.302.797.3100 (collect calls accepted) 1.800.243.6998 001.302.797.3150	
Secure Website:	www.CignaEnvoy.com. Registration is Required (See member kit for registration information.) Secure email available at this site.	
Mail Delivery:	Cigna Global Health Benefits P.O. Box 15050 Wilmington DE 19850-5050 U.S.A.	Cigna Global Health Benefits 300 Bellevue Parkway Wilmington DE 19809 U.S.A.

General Plan Provisions - All Amounts in U.S. Dollars

Global Medical Plan

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Area of Cover	Worldwide		
U.S. Medical Network	PPO		
Eligibility	Refer to eligibility definition in the certificate		
Lifetime Maximum	Unlimited		
Annual Maximum	Unlimited		
Calendar Year Deductible · Per Individual	$0	$200	$200
· Per Family	$0	$400	$400
Coinsurance (The percentage of covered expenses the plan pays)	90%	90%	70%
Out-of-Pocket Maximum (Includes Deductible) · Per Individual	$1,500	$1,500	$3,000
· Per Family	$3,000	$3,000	$6,000

Global Medical Plan	
Deductible Calculation	Claims for a family member are covered at plan coinsurance: • When that family member satisfies the Individual Deductible -OR- • When the Family Deductible is satisfied regardless of whether or not the Individual Deductible is satisfied.
Out-of-Pocket Calculation	Claims for a family member are covered at 100% coinsurance: • When that family member satisfies the Individual Out-of-Pocket Maximum -OR- • When the Family Out-of-Pocket Maximum is satisfied regardless of whether or not the Individual Out-of-Pocket Maximum is satisfied. Out-of-Pocket will: Include deductible payments; Include copay payments; Include pharmacy copays; Include pharmacy coinsurance payments; Benefit Not Covered Pre-Admission Certification/Continued Stay Review penalties.
Network Accumulation	Plan Deductible, Out-of-Pocket, maximums and service specific maximums (dollar and occurrence) will cross-accumulate across international and domestic networks.

Certification Requirements - For services rendered inside the United States

Precertification for inpatient and outpatient services received in the U.S. may be required.

- Providers must call our toll-free number, 1.800.441.2668 to pre-certify services.
- You or your dependents are responsible for ensuring that Out-of-Network providers pre-certify services.
- Failure to obtain precertification may affect Out-of-Pocket costs.
- This is a summary only and further details can be found in the certificate booklet.

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Physician's Services · Physician's Office Visit	90%	90% after deductible	70% after deductible
· Surgery Performed In the Physician's Office	90%	90% after deductible	70% after deductible
Preventive Care			
· Routine Preventive Care - Adult	100%	100% not subject to deductible	100% not subject to deductible
· Immunizations - Adult	100%	100% not subject to deductible	100% not subject to deductible
· Routine Preventive Care - Child	100%	100% not subject to deductible	100% not subject to deductible
· Immunizations - Child	100%	100% not subject to deductible	100% not subject to deductible
Travel Immunizations (Immunizations as required for travel)	100%	100% not subject to deductible	100% not subject to deductible
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100%	100% not subject to deductible	100% not subject to deductible
Inpatient Hospital			
· Inpatient Hospital - Facility Services (Limited to the Semi-Private Room Rate)	90%	90% after deductible	70% after deductible
· Inpatient Hospital Physician Visits/Consultations	90%	90% after deductible	70% after deductible
· Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	90%	90% after deductible	70% after deductible
Outpatient Services			
· Outpatient Facility Services	90%	90% after deductible	70% after deductible
· Outpatient Professional Services	90%	90% after deductible	70% after deductible
Emergency Room	90%	90% after deductible	90% after deductible
Urgent Care Services	90%	90% after deductible	60% after deductible
Ambulance	90%	100% after deductible	100% after deductible

Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Laboratory Services			
· Physician Office Visit	90%	90% after deductible	70% after deductible
· Outpatient Facility	90%	90% after deductible	70% after deductible
· Laboratory Services at an Independent Lab facility	90%	90% after deductible	70% after deductible
Radiology Services			
· Physician Office Visit	90%	90% after deductible	70% after deductible
· Outpatient Facility	90%	90% after deductible	70% after deductible
Advanced Radiology (i.e., MRIs, MRAs, CAT Scans, PET Scans)			
· Physician Office Visit	90%	90% after deductible	70% after deductible
· Inpatient Facility	90%	90% after deductible	70% after deductible
· Outpatient Facility	90%	90% after deductible	70% after deductible
Outpatient Therapy Services			
· Physician Office Visit	90%	90% after deductible	70% after deductible
· Outpatient Hospital Facility	90%	90% after deductible	70% after deductible
Calendar Year Maximum:	Unlimited for all Therapies Combined		
The limit is not applicable to Mental Health and Substance Use Disorder conditions. **Note:** The Outpatient Therapy Services maximum does not apply to the treatment of Autism *Includes:* Cardiac and Pulmonary Rehab, Speech, Occupational and Cognitive Therapy			

Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Outpatient Therapy Services - Physical Therapy / Physiotherapy			
· Physician Office Visit	90%	90% after deductible	70% after deductible
· Outpatient Hospital Facility	90%	90% after deductible	70% after deductible
Calendar Year Maximum: Unlimited for all Therapies Combined			
Chiropractic Care Calendar Year Maximum: Unlimited	90%	90% after deductible	70% after deductible
Maternity Care Services			
· Initial Visit to Confirm Pregnancy	90%	90% after deductible	70% after deductible
· All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	90%	90% after deductible	70% after deductible
· Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	90%	90% after deductible	70% after deductible
· Delivery – Facility			
· Inpatient Hospital	90%	90% after deductible	70% after deductible
· Birthing Center	90%	90% after deductible	70% after deductible

Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Infertility, Fertility and Conception Services	Coverage will be provided for the following services: · GIFT, ZIFT, etc. · In-vitro · Artificial Insemination		
· Physician Office Visit and Counseling	90%	90% after deductible	70% after deductible
· Lab and Radiology Tests	90%	90% after deductible	70% after deductible
· Inpatient Facility	90%	90% after deductible	70% after deductible
· Outpatient Facility	90%	90% after deductible	70% after deductible
Hearing Exam	Not Covered	Not Covered	Not Covered
Hearing Device / Aids · Limited to Dependent Children Under 24 Years · 1 Per Ear Every 36 Months up to $1,000	90%	90% after deductible	70% after deductible
Mental Health · Physician Office Visit	90%	90% after deductible	70% after deductible
· Inpatient Facility	90%	90% after deductible	70% after deductible
Maximum: (combined with Substance Use Disorder)	Unlimited		
· Outpatient Facility	90%	90% after deductible	70% after deductible
Maximum: (combined with Substance Use Disorder)	Unlimited		
Substance Use Disorder · Physician Office Visit	90%	90% after deductible	70% after deductible
· Inpatient Facility	90%	90% after deductible	70% after deductible
Maximum: (combined with Mental Health)	Unlimited		
· Outpatient Facility	90%	90% after deductible	70% after deductible
Maximum: (combined with Mental Health)	Unlimited		
Important Note on Mental Health & Substance Use Disorder Coverage: Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to the sections titled "Mental Health" and "Substance Use Disorder".			

Prescription Drug Benefits		
International (Outside of the U.S.)		
Purchased outside the United States	You pay 10% not subject to plan deductible	
Certain preventive care medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no copayment or deductible, when purchased from a Network Pharmacy. A written prescription is required.		
Purchased Inside the United States Only		
Benefit Highlights	**Network Pharmacy (U.S. In-Network)**	**Non-Network Pharmacy (U.S. Out-of-Network)**
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 30-day supply**	
Tier 1 - Generic Drugs on the Prescription Drug List	You pay 10% not subject to plan deductible	You pay 40% after plan deductible
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	You pay 10% not subject to plan deductible	You pay 40% after plan deductible
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	You pay 10% not subject to plan deductible	You pay 40% after plan deductible
Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive 90-day supply**	
Tier 1 - Generic Drugs on the Prescription Drug List	You pay 10% not subject to plan deductible	In-Network coverage only
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	You pay 10% not subject to plan deductible	In-Network coverage only
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	You pay 10% not subject to plan deductible	In-Network coverage only

Pharmacy Plan Features for Prescriptions Drugs Purchased Inside the United States Only	
Prescription Drug List	Performance 3-Tier
Dispense As Written	If you request to fill a brand name drug that has a generic equivalent available, you will be financially responsible for the difference in cost between the brand name and the generic drug, plus any required brand name drug copayment and/or coinsurance, if applicable. However, if your doctor has determined a generic drug is not an acceptable alternative for you, you will only be responsible for payment of the appropriate brand name drug copayment and/or coinsurance, if applicable
Utilization Management	Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for your medical condition
Step Therapy	Certain drugs are subject to step therapy requirements. To identify whether a particular drug is subject to step therapy, please refer to your prescription drug list.
Prior Authorization	Coverage for certain drugs require your Physician to obtain prior authorization from Cigna. To identify whether a particular drug requires prior authorization, please refer to your prescription drug list.
Quantity Limits	Includes maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
Patient Assurance Program	Your plan includes the Patient Assurance Program, which waives the deductible, if applicable, and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally: •Any amount you pay for these medications only count toward meeting your out-of-pocket maximum, if applicable. •Any discount provided by a pharmaceutical manufacturer for these medications only count toward meeting your out-of-pocket maximum, if applicable.
To see if your medication is covered, you can view Cigna's Prescription Drug List by going to www.Cigna.com/druglist and select "Performance 3-Tier"	

International Employee Assistance Program (IEAP)	
Toll Free:	1.888.851.7032 or 1.877.857.2952
Reverse Charge Number:	+44 208 987 6230
Level 3 International EAP Assist & Work/Life	Direct dial 24/7 immediate access to confidential services for behavioral issues. Services include telephonic triage for emergent and urgent referrals, crises intervention and referrals to community resources. Referrals for 6 face-to-face sessions with licensed behavioral professional. Includes work-life referrals for childcare, eldercare, legal and financial situations.

Global Telehealth	
Teladoc Health International	Available 24/7 via the Cigna Wellbeing App and Envoy Home Page (cignaenvoy.com),Global Telehealth gives you access to licensed doctors around the world. • Video or phone consultations with licensed doctors when medically necessary • Prescriptions for common health concerns when medically necessary and permitted • Treating medical conditions like fever, rash, pain and more • Assistance with preparations for an upcoming consultation • Discussing medication plan and potential side effects • Diagnosing non-emergency health issues ranging from acute conditions to complex chronic conditions

Global Vision Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Examinations One every Calendar Year	100%	100% not subject to deductible	
Exam Maximum Benefit			
Frames One every Calendar Year	100%	100% not subject to deductible	
Frames Maximum	$200		
Lenses One pair every Calendar Year Single Lenses Bifocal Lenses Trifocal Lenses Lenticular Lenses Tints and Coating Or Contact Lenses	100%	100%	
Single Lenses Maximum	$175		
Bifocal Lenses Maximum	$175		
Trifocal Lenses Maximum	$175		
Lenticular Lenses Maximum	$175		
Tints and Coating Maximum	$200		
Contact Lenses Maximum	$190		

Global Dental Plan		
Calendar Year Maximum Combined for: Class I Class II Class III		$2,000
Lifetime Class IV Maximum		$2,000
Lifetime Class V Maximum		$2,000
Calendar Year Deductible Combined for: Class II Class III Class IV Class V		$50 Individual / $100 Family
Class I	**Preventive Care** For diagnostic and preventative services including: • Oral Exam -2 Per Person Per Year • Cleanings -2 Per Person Per Year • Bitewing X-rays -2 Per Person Per Year • Fluoride Applications -1 Per Person Per Year (Up to age 19) • Sealants -1 Treatment per Posterior Tooth per 3 Years • Diagnostic X-rays –Unlimited • Full Mouth / Panoramic X-rays -1 Per Person Per 3 Years	100% not subject to deductible
Class II	**Basic Restorative** For Basic Restorations: • Endodontics • Periodontics • Prosthodontics Maintenance • Oral Surgery • Fillings • Root Canal • Periodontal Scaling and Root Planing • Repair to Bridgework and Dentures	80% after deductible
Class III	**Major Restorative** For Major Restorations: • Dentures • Bridgework • Crowns	50% after deductible
Class IV	**Orthodontia** Children and Adults	50% after deductible
Class V	**Implants**	80% after deductible